Frederick County Division of Fire and Rescue Services
Consent Form with Assignment of Benefits Authorization

Patient Name: _____ **Transport Date:** _____

Incident # _____ **Unit #** _____

BILLING AUTHORIZATION AND RESPONSIBILITY FOR PAYMENT

I request that payment of authorized Medicare/Medicaid and other insurance benefits be made on my behalf to Frederick County or its billing agent for any transport services provided to me by Frederick County EMS now or in the future. I understand that I am financially responsible for transport services provided to me by Frederick County EMS regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Frederick County EMS any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payment to Frederick County EMS. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to Frederick County EMS and its billing agents, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Frederick County EMS, now or in the future. I authorize Frederick County EMS and its billing agents to appeal payment denials or other adverse decisions on my behalf without further authorization. A copy of this form is as valid as the original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I understand my privacy rights concerning protected health information (PHI) and how to obtain a copy of the Patient Privacy Notice.

SIGNATURE SECTION:

One of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

This Section is for **emergencies or non-emergencies**.
The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____ _____

Patient Signature or Mark Date

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an ambulance crew member.

X _____ _____

Witness Signature Date

_____

Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for **emergencies or non-emergencies**. Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____ _____

Representative Signature Date Printed Name of Representative

DFRS – Original Station – Yellow Copy Patient – Pink Copy